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No. 90-328

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BODIMETRIC HEALTH SERVICES, *et al.*,
Petitioners,

v.

AETNA LIFE and CASUALTY COMPANY and
AETNA LIFE INSURANCE COMPANY,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether 42 U.S.C. §§ 405(h) or 1395ff bars federal court jurisdiction over state law claims for monetary damages made by a health care provider against a Medicare fiscal intermediary when those claims are based upon allegations that the intermediary wrongly denied Medicare benefit claims submitted by the provider.

LIST OF PARTIES

All of the respondents are listed in the caption of the petition. The statement required by Rule 29.1 is included in the Appendix to this petition. App., *infra*, 1a-2a.

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RESPONDENTS' BRIEF IN OPPOSITION

STATEMENT

This case involves a dispute about whether certain individual benefit claims submitted for reimbursement by a health care provider under the Medicare program were erroneously denied. Petitioner Bodimetric Health Services, Inc., a home health care agency, has alleged that approximately 26,000 such benefit claims submitted by it over a period of several years were incorrectly determined by Aetna Life Insurance Company and Aetna Life and Casualty Company (collectively "Aetna").[1] Pet. 7.

[1] Petitioners Bodimetric Home Care, Inc. and American Service Bureau, Inc. are affiliates of Bodimetric Health Services, Inc. (Pet. ii). These two affiliates have alleged that they also suffered

Aetna passed on the merits of each of these individual claims in its role as "fiscal intermediary" under Part A of the Medicare program.[2]

In their complaint, petitioners sought to impose liability upon Aetna for these disputed benefit determinations. However, the courts below both found that the Medicare Act bars federal jurisdiction over this action. These rulings are grounded on a recognition that intermediaries like Aetna play a central role in the federal government's administration of the Medicare program and that Congress has established exclusive mechanisms for dealing with disputes concerning intermediary determinations. To appreciate this holding, a brief description of the statutory framework and of the function of fiscal intermediaries in the Medicare program is necessary.

A. The Medicare Program and the Role of Fiscal Intermediaries

The Medicare Act, 42 U.S.C. § 1395, *et seq.*, provides health insurance for the aged and disabled. Coverage under the Act is divided into two parts. Part A of the Medicare program covers costs incurred by eligible beneficiaries for services provided by hospitals and certain other institutional providers, including home health care agencies. 42 U.S.C. §§ 1395c-1395i-3. Part B of the program provides elective supplemental coverage for physician services and certain other health services. 42 U.S.C. §§ 1395j-1395w-2.

Overall responsibility for implementation of the Medicare program is vested with the Secretary of the Depart-

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consequential damages as a result of the denials of claims submitted by Bodimetric Health Services, Inc. For purposes of this brief, all three petitioners are referred to collectively as "Bodimetric."

[2] See Pet. App. 14a n.6; *id.* at 36a ("Aetna acted in its capacity as fiscal intermediary when it reviewed plaintiffs' claims, even if it reviewed them improperly for base and fraudulent reasons").

ment of Health and Human Services ("HHS"). The Secretary is authorized by statute, however, to contract with public or private agencies to act as "fiscal intermediaries" for purposes of administering Part A of the program.[3] 42 U.S.C. § 1395h. Each fiscal intermediary is charged with making "the determination[s] . . . of the amount of payments required . . . to be made to [eligible health care] providers." 42 U.S.C. § 1395h(a). In order to carry out this responsibility, the intermediary must review each reimbursement claim to ensure, *inter alia*, that the services were actually provided, were covered by the Part A program, and were medically necessary. See Pet. App. 3a n.3, 4a. Congress has declared that in performing these functions, fiscal intermediaries "act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program . . . ." S. Rep. No. 404, 89th Cong. 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1995.

Fiscal intermediaries review literally tens of millions of reimbursement claims every year, and make individual benefit amount determinations regarding each of them. *Cf. Heckler* v. *Ringer*, 466 U.S. 602, 627 n.14 (1984) ("In 1982 there were 48 million claims filed under Part A of the Medicare Program"). Because of the potentially overwhelming volume of disputes about these benefit determinations, the Medicare Act provides a carefully crafted set of procedures for review of an intermediary's benefit amount determinations. See 42 U.S.C. § 1395ff(b). If a claim for reimbursement under the Act is denied, in whole or in part, a provider may

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[3] Similar contractual arrangements are authorized under Part B of the program. 42 U.S.C. § 1395u. The organizations hired to perform these tasks under Part B of the Medicare program are called "carriers." 45 Fed. Reg. 42174 (June 23, 1980). See generally *United States* v. *Erika, Inc.*, 456 U.S. 201, 203 (1982).

first request reconsideration by the intermediary. 42 C.F.R. § 405.710(b). If the claim involves more than $100, the provider has a right to review of the reconsidered decision by an administrative law judge. 42 U.S.C. § 1395ff(b)(2)(A); 42 C.F.R. § 405.720. If still not satisfied, the provider may request further review by the Appeals Council of HHS. 42 C.F.R. § 405.724. Finally, if the amount in controversy of aggregated disputed denials exceeds $1,000, the provider has a right of appeal to a United States District Court. 42 U.S.C. § 1395ff(b)(2)(B); 42 C.F.R. § 405.730.

These procedures for review of benefit amount determinations are intended to be exclusive. *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982) ("the statute's precisely drawn provisions . . . provide[] persuasive evidence that Congress deliberately intended to foreclose further review of such claims"); *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667, 674-76 (1986) (holding that Medicare's legislative history "provides persuasive evidence that Congress deliberately intended to foreclose further review" of "determinations of amount"). Moreover, the remedies provided by these review procedures are to be the sole remedies for erroneous benefit amount determinations. "It is intended that the remedies provided by these review procedures shall be exclusive." S. Rep. No. 404, 89th Cong., 1st Sess., 54-55 (1965). See also H.R. Rep. No. 213, 89th Cong., 1st Sess. 42 *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1995.

B. Course of Proceedings

Invoking the diversity jurisdiction of the district court pursuant to 28 U.S.C. § 1332, Bodimetric alleged that Aetna had wrongfully denied claims for approximately 26,000 home health care visits. Bodimetric claimed that Aetna should be subject to liability for these denials under a variety of state common law theories—including

negligence, breach of contract, breach of third-party beneficiary relationship, breach of implied covenant of good faith and fair dealing, breach of fiduciary duty, and fraud—as well as under civil RICO, 18 U.S.C. § 1961 *et seq.* Pet. App. 4a. As a remedy, Bodimetric sought payment from Aetna of damages arising from these allegedly incorrect benefit determinations. *Id.* at 34a. ("plaintiffs' damages flow directly from benefit denials"). In particular, Bodimetric sought direct damages (consisting of the value of denied benefit amounts), consequential damages (*i.e.*, damages allegedly suffered from loss of the use of denied benefit amounts), and punitive damages.

Aetna moved to dismiss the complaint for lack of subject matter jurisdiction and on other grounds.[4] Specifically, Aetna argued that petitioners' action was barred by the exclusive review mechanisms established by the Medicare Act for review of intermediary benefit determinations, *i.e.*, 42 U.S.C. §§ 1395ff and 405(h). The United States, concurring with Aetna, moved to intervene and also filed a motion to dismiss on similar grounds.[5]

The district court granted Aetna's motion to dismiss, finding that "Congress intended the remedies provided by these review procedures to be exclusive." Pet. App. 25a. "Congress adopted a system for challenging benefit

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[4] Aetna also raised official immunity, sovereign immunity and preemption defenses to the entire complaint. In addition, Aetna moved to dismiss individual counts of the complaint based on more particularized deficiencies. Because of their holdings that petitioners' complaint was barred by 42 U.S.C. §§ 1395ff and 405(h), however, neither the district court nor the court of appeals decided these alternative grounds for dismissal.

[5] Because of its dismissal of Bodimetric's complaint, the district court denied as moot the government's motion to intervene. Pet. App. 36a. In order to protect its rights as the "real party in interest" (see p. 14 n.12, *infra*), the government appealed the denial of its motion. The Seventh Circuit did not consider the government's motion on appeal. Pet. App. 20a n.10.

determinations and providers cannot, by creative lawyering, avoid the strictures of that system." *Id.* at 34a. In this regard, the court noted that petitioners' claims were "at bottom, for a review of the intermediary's benefit determinations." *Id.* The court recognized that if the case were to proceed, the merits of each of these benefit determinations would be squarely at issue, and Aetna would be "entitled to dispute plaintiffs' conclusions claim-by-claim." *Id.* The court concluded that it could not, consistent with congressional intent, "now make its own determination that thousands of services were reasonable and necessary and that therefore thousands of benefits should have been paid." *Id.* at 36a.

On appeal, the Seventh Circuit affirmed unanimously. The court held that "[w]hether its complaint is with Aetna's rejection of one claim or a thousand claims" (Pet. App. 11a), Bodimetric's action "at bottom" challenged intermediary benefit amount determinations and "therefore [was] subject to the exclusive review provisions of section 1395ff" (*id.* at 14a). Moreover, the Seventh Circuit rejected petitioners' argument that Section 1395ff should be deemed inapplicable because their complaint was styled as a damages action against the intermediary:

> A party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Pet. App. 13a-14a. The court further rejected petitioners' contention that Section 1395ff was inapplicable because the complaint sought remedies, *e.g.*, punitive dam-

ages, exceeding those available in Medicare administrative proceedings:

> . . . Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal intermediaries. While this may, in some cases, foreclose avenues of relief generally available to civil litigants, it is also the system Congress clearly intended to implement.

Id. at 20a-21a. See also *id.* at 13a n.5; S. Rep. No. 404, *supra*, at 54-55 ("It is intended that the remedies provided by these review procedures shall be exclusive").

The court of appeals also held that the third sentence of 42 U.S.C. § 405(h) posed a jurisdictional bar to petitioners' diversity action.[6] That sentence states: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." The court found that petitioners' claims "arose under" the Medicare Act because they were "inextricably intertwined" with the merits of individual benefit determinations. Pet. App. 6a-7a. The court further found that a fiscal intermediary is, for purposes of Section 405(h) an "officer or employee" of the Secretary. *Id.* at 14a-15a. Finally, after determining that a 1984 revision of Section 405(h) had not been intended to alter that provision's previously express applicability to diversity actions, the court held that Section 405(h) continues to apply to diversity actions. *Id.* at 16a-20a.

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[6] Section 405(h) is incorporated into the Medicare Act by 42 U.S.C. § 1395ii.

REASONS FOR DENYING THE PETITION

This case does not warrant review by this Court. There is no conflict between the decision below and the decisions of any other court of appeals or of this Court. As petitioners themselves concede (Pet. 15), the only appellate decision that they claim conflicts with the Seventh Circuit's holding that Section 405(h) applies to diversity actions did not, in fact, address that question. Moreover, the Seventh Circuit's careful analysis of the codification history of Section 405(h), which is essential to an understanding of that provision's scope, is so clearly correct that petitioners have not even bothered to mention it, much less to suggest any flaw in that analysis.

Petitioners' attempt to manufacture a conflict between *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), and the decision below is similarly groundless. *Michigan Academy* permitted "challenges mounted against the *method* by which [Medicare benefit] amounts are to be determined rather than the *determinations* themselves." *Id.* at 675 (emphasis in original). Here, however, petitioners' allegation that more than 26,000 of their benefit claims were improperly denied *does* challenge the merits of "the determinations themselves," as both the district court and the court of appeals found. Therefore, it is properly subject to the exclusive review procedures and remedies provided by the Medicare Act. Every court of appeals considering similar challenges since *Michigan Academy* has reached an identical conclusion. See pp. 11-12, *infra*.

Finally, the "Question Presented" by petitioners addresses only Section 405(h). However, a separate statutory provision also addressed by the court below, *i.e.*, 42 U.S.C. § 1395ff, independently supports the judgment. As this Court has held, section 1395ff carries its own preclusive force. *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982). Indeed, as the lower courts in this case correctly recognized, Congress has expressly indicated that the rem-

edies that the Act provides for incorrect benefit determinations by intermediaries are meant to be exclusive. Pet. App. 4a. Thus, petitioners' request for review only of issues pertaining to Section 405(h) is pointless. There is an independent and unchallenged ground for sustaining the judgment.

1. Petitioners claim that a direct conflict exists between the Seventh Circuit's holding that Section 405(h) applies to diversity actions and the decision of the Eighth Circuit in *Rochester Methodist Hospital* v. *Travelers Ins. Co.*, 728 F.2d 1006 (8th Cir. 1984). In fact, there is no conflict because *Rochester* did not even address the scope of Section 405(h). As petitioners themselves recognize (Pet. 15), "the *Rochester* opinion expressly addresses only timeliness of appeal and sovereign immunity as possible bars to judicial review . . . ."

The court in *Rochester* held only that the "sovereign immunity of the United States . . . does not protect Travelers from personal liability for its own tort." 728 F.2d at 1008. The Court simply did not analyze the effect of Section 405(h) on the jurisdiction of the district court. Indeed, Section 405(h) is mentioned only in a footnote which recited certain proceedings in the district court. *Id.* at 1010 n.6.

Based upon this one isolated reference and the fact that the district court in that case permitted diversity claims to proceed, petitioners seek to extract from the Eighth Circuit's opinion a "*sub silentio* ruling" (Pet. 15) that Section 405(h) does not apply to diversity actions. However, the complete absence of discussion, analysis, or even acknowledgment of any such issue in *Rochester* prevents that decision from bearing the weight that petitioners seek to give it.

Further, even if petitioners were correct in their claim of a "*sub silentio* ruling," this Court has consistently recognized that *sub silentio* assumptions of jurisdic-

tion have no precedential value.[7] See, *e.g.*, *Hagans* v. *Lavine*, 415 U.S. 528, 535 n.5 (1974) ("[W]hen questions of jurisdiction have been passed on in prior decisions *sub silentio*, this Court has never considered itself bound" but approaches the question "as an open one"); *Will* v. *Michigan Dept. of State Police*, 109 S.Ct. 2304, 2307 n.4 (1989). Thus, *Rochester*'s silence cannot create a precedential conflict with the Seventh Circuit's reasoned analysis.

Finally, it is telling that petitioners are themselves unable to articulate any purported error in the Seventh Circuit's careful analysis of why Section 405(h) applies to diversity actions. Petitioners do not and cannot deny that as originally enacted, Section 405(h) expressly encompassed diversity actions.[8] Pet. App. 17a. Petitioners also do not dispute that when the wording of Section 405(h) was changed by Congress in 1984 as part of a

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[7] In fact, petitioners have not cited and we are not aware of any published opinion that relies upon *Rochester* for the proposition that Section 405(h) does not apply to diversity actions.

Moreover, in a case decided subsequent to *Rochester*, the Eighth Circuit itself determined that fiscal intermediaries are not subject to common law actions by providers. In *Bushman* v. *Seiler*, 755 F.2d 653, 655 (8th Cir. 1980), the court held that Medicare intermediaries are "governmental agents for immunity purposes," and therefore enjoy absolute immunity from common law tort liability for actions performed in their capacity as intermediaries. *Barr* v. *Matteo*, 360 U.S. 564, 573-74 (1959). While *Bushman*, like *Rochester*, did not address Section 405(h), the net effect of that opinion is that in the Eighth Circuit, as elsewhere, it is clearly the rule that state law causes of actions may not be maintained against intermediaries.

[8] "The literal wording of this section [405(h)] bars actions under 28 U.S.C. § 41. At the time § 405(h) was enacted, and prior to the 1948 recodification of Title 28, § 41 contained all that title's grants of jurisdiction to United States district courts, save for several special-purpose jurisdictional grants . . . ." *Weinberger* v. *Salfi*, 422 U.S. 749, 756 n.3 (1975). Among Section 41's jurisdictional grants was "the predecessor to the current diversity grant, 28 U.S.C. Section 1332." Pet. App. 17a.

pro forma package of technical codification corrections, Congress expressly declared "its intent not to alter the substantive scope of section 405(h)." *Id.* at 19a. Consequently, it would defy the express statutory command of Congress to find diversity actions excluded from the scope of the recodified Section 405(h). Given petitioners' complete failure to challenge the Seventh Circuit's analysis of these issues, there is no basis for this Court to review its holding.

2. Petitioners also allege a conflict between the decision below and this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). However, they are unable to cite any holding of *Michigan Academy* not followed by the Seventh Circuit. Petitioners correctly characterize *Michigan Academy* as holding "that sections 405(h) and 1395ff [do] not preclude judicial review under federal question jurisdiction of the *methods* by which [Medicare] payments are computed, as opposed to *the computation of a specific payment amount.*" Pet. 16 (emphasis supplied). But the Seventh Circuit found that petitioners' complaint here did not concern the propriety of the governing "methods" for calculating benefits. Instead, the complaint was "at bottom" an aggregation of grievances about payment amounts that petitioners had not received, and therefore their claim fell on the wrong side of the *Michigan Academy* dichotomy. Pet. App. 14a.

In reaching this conclusion the Seventh Circuit followed a unanimous chain of precedents that have applied *Michigan Academy* in identical fashion. See, *e.g.*, *Kuritzky* v. *Blue Shield*, 850 F.2d 126, 128 (2d Cir. 1988), *cert. denied*, 488 U.S. 1006 (1989) ("'method' does not mean the carrier's method of applying the regulations, which *Erika* held was unreviewable"); *Association of Seat Lift Mfrs.* v. *Bowen*, 858 F.2d 308 (6th Cir. 1988), *cert. denied*, 109 S. Ct. 1528 (1989); *Texas Medical Ass'n* v. *Sullivan*, 875 F.2d 1160 (5th Cir.), *cert. denied*, 110 S. Ct. 573 (1989). Indeed, while petitioners

assert that there "has been confusion in the lower courts" regarding *Michigan Academy* (Pet. 17 n.12), the plain fact is that no court has interpreted *Michigan Academy* as sanctioning an action that attacks the merits of benefit determinations, much less one that seeks damages against the intermediaries making those determinations.[9]

In view of this unanimous weight of authority, petitioners do not take issue with the Seventh Circuit's finding that their complaint does not involve a challenge to "the *method* by which such [benefit] amounts are to be determined rather than by the *determinations* themselves." *Michigan Academy*, 476 U.S. at 675. Instead, ignoring the Seventh Circuit's faithfulness to the actual holding of *Michigan Academy*, petitioners accuse that court of having violated statements in *Michigan Academy* recognizing "the presumption in favor of reviewability." Pet. 20. But *Michigan Academy* itself recognized that, notwithstanding this general presumption, the Medicare statutory scheme and legislative history manifest a clear intent to limit reviewability of intermediary benefit determinations.[10] *Michigan Academy*, 476 U.S. at 674-75.

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[9] The two decisions cited by petitioners (Pet. 18 n.12) are in line with all the other decisions on this issue. In *McCuin* v. *Secretary of Health and Human Servs.*, 817 F.2d 161 (1st Cir. 1987), the plaintiff challenged the propriety of a reopening procedure utilized by the Secretary. In finding jurisdiction over this limited challenge, the court was careful to note that plaintiff "did not argue the merits of her Medicare claim" (*id.* at 163), but conceded that "§ 1395ff bars her from making such an argument" (*id.* at 165). Similarly, *Medical Fund-Philadelphia Geriatric Center* v. *Heckler*, 804 F.2d 33 (3rd Cir. 1986), did not require adjudication of the merits of individual benefit determinations, but instead involved a challenge to the legality of an HHS policy. In short, in contrast to this case, neither of these decisions involved the merits of benefit determinations or sought "damages" for allegedly erroneous determinations.

[10] At times, petitioners seem to imply that the applicability of Sections 1395ff or 405(h) depends upon whether the dollar amounts

Petitioners claim, however, that "the language and the legislative history of sections 405(h) and 1395ff are silent" on the issue of potential remedies under state law theories. Pet. 19. This assertion is simply wrong. See Pet. App. 9a-14a. The uncontradicted legislative declaration at the time of the enactment of Section 1395ff was that, "[i]t is intended that the remedies provided by these review procedures shall be exclusive." S. Rep. No. 404, 89th Cong., 1st Sess., 54-55 *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 208-209 n.11 (1982). Similarly, Section 405(h) can hardly be said to be silent on the issue of state law remedies when it clearly precludes diversity actions (see pp. 10-11, *supra*), which by their very nature seek remedies based on state law.

Finally, petitioners contend that the decision below conflicts with *Michigan Academy* because it applies Sections 1395ff and 405(h) to an action that seeks damage remedies not available in administrative proceedings under the Medicare Act. Pet. 18-19 and n.13. But *Michigan Academy* did not involve a case in which damages were sought and did not decide any issue regarding whether those statutory sections apply to actions for damages. Rather, this Court in *Michigan Academy* was careful to hold only that procedural challenges—which do not require consideration of the merits of individual benefit determinations—fall outside the scope of Sections 1395ff and 405(h).

When, as here, however, an action has been found to be "inextricably intertwined" with the merits of individ-

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involved are large or small. See Pet. 18-19. *Michigan Academy* turns on the nature of the challenge, however, not on the size of the dollar amounts or the number of claims that a dissatisfied provider asserts to be at issue. As the Seventh Circuit correctly noted, the governing principles remain the same whether "one claim or a thousand" is involved. Pet. App. 11a.

ual benefit determinations, this Court has not hesitated to find it subject to the Medicare Act's exclusive procedures. *Heckler* v. *Ringer*, 466 U.S. 602, 614-17 (1984). This has been true regardless of the form of the action and regardless of the nature or characterization of the relief sought.[11] *Id.* at 621 (rejecting any action, regardless of form, that "would allow claimants substantially to undercut Congress' carefully crafted scheme for administering the Medicare Act"). As this Court has recognized, any other approach would violate the Congressional purpose, acknowledged even by petitioners, of excluding jurisdiction over "amount determination disputes."[12] Pet. 18.

3. In any event, this case is not an appropriate one for deciding the question presented by petitioners con-

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[11] In virtually any instance of denied benefits, an inventive plaintiff would be able to allege damages not recoverable under the Medicare Act, *e.g.*, consequential damages (such as lost interest that could have been earned on denied reimbursement amounts, which is among the items for which petitioners here sought recovery). Consequently, allowing a "demand for greater damages than the statute provides would render meaningless the jurisdiction restriction . . . ." *Marin* v. *HEW, Health Care Financing Agency*, 769 F.2d 590, 590 (9th Cir. 1985), *cert. denied*, 474 U.S. 1061 (1986). Indeed, given the Congressional intent to establish an *exclusive* scheme of remedies (see p. 4, *supra*), it would be contradictory to allow an action to proceed *because* it sought additional remedies.

[12] Although petitioners persist in referring to Aetna as "a private party" (see, *e.g.*, Pet. 19), the preclusive force of Sections 1395ff and 405(h) apply as much to actions against the intermediary as to actions against HHS. Not only do petitioners fail to challenge the Seventh Circuit's ruling on this issue (Pet. App. 14a-15a), no court has ever held to the contrary. Indeed, in *Erika* this Court specifically noted that even though plaintiff's arguments in that case "were directed in large measure against the actions" of the Medicare carrier, "the Administrator of the Health Care Financing Administration 'is the real party of interest in any litigation involving the administration of the [Medicare] program.'" 456 U.S. at 206, n.4.

cerning the scope of Section 405(h). Pet. (i). This is because Section 1395ff provides a wholly independent basis for upholding the judgment that the district court lacked jurisdiction over petitioners' action. It is well-established that Section 1395ff possesses preclusive force in its own right, separate and apart from Section 405(h). Indeed, in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), this Court held that judicial review of benefit determinations is impliedly prohibited by Section 1395ff—without ever resolving alternative contentions regarding Section 405(h). *Id.* at 206, n.6.[13]

Given that Section 1395ff provides an independent basis for sustaining the Seventh Circuit's judgment—and one that is particularly powerful in view of the explicit legislative history on the issue of exclusivity of remedies provided by that section (see pp. 4-5, *supra*) —there is no reason for this Court to grant petitioners' request to review issues pertaining only to Section 405(h). Because Section 1395ff by itself is outcome determinative in this case, the restricted review proposed by petitioners would be merely an academic exercise, and inappropriate for that reason. As this Court has previously noted, "[t]his Court 'reviews judgments, not statements in opinions.'" *California* v. *Rooney*, 483 U.S. 307, 311 (1987) (citation omitted). Accord *Chevron U.S.A.* v. *National Resources Defense Council*, 467 U.S. 837, 842 (1984).

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[13] After finding that petitioners' action "is subject to the exclusive review provisions of section 1395ff," the court of appeals stated that this conclusion "does not end our inquiry, however," and proceeded to examine Section 405(h). Pet. App. 14a. To the extent that the court of appeals thereby assumed that both Section 1395ff *and* Section 405(h) must be satisfied in order for Section 1395ff to have preclusive force, this assumption, though harmless, was clearly incorrect in light of *Erika*.

* * * *

Petitioners seek to project an image of future unbridled abuses if the Seventh Circuit opinion stands. However, that image is flawed. The Medicare program has operated successfully for almost a quarter of a century without having intermediaries and carriers subject to threats of liability for their benefit determinations.[14] If anything threatens to disrupt the administration of that program, it is not the continuation of these restrictions on private actions but the potential of intermediary liability for each of tens of millions of benefit determinations. As this Court has analogously observed in refusing to expand the remedies available for wrongful termination of Social Security disability benefits, such a prospect "would undoubtedly lead to new difficulties and expense in recruiting administrators for the programs Congress has established." *Schweiker* v. *Chilicky*, 487 U.S. 412, 425 (1988).

In sum, the limitations on remedies available to aggrieved claimants under the Medicare Act reflect a deliberate Congressional judgment designed to aid in the efficient administration of that program. To the extent that petitioners object to these limitations, their objection is properly addressed to Congress—not to this Court.

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[14] Each intermediary's performance remains subject to extensive HHS oversight. For example, HHS has the power to terminate an intermediary contract where it can be shown that the intermediary has failed to meet applicable requirements. 42 C.F.R. §§ 421.124, 421.126.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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November 16, 1990

* Counsel of Record

APPENDIX

APPENDIX

APPENDIX

Respondent Aetna Life Insurance Company is a wholly owned subsidiary of Aetna Life and Casualty Company. Respondent Aetna Life Insurance Company has an interest in, but does not wholly own, the following subsidiaries:

Dayton Arcade Community Urban Redevelopment Corporation, Thace Associates, Algonquin Mills, Friday Associates, Koll Center Newport A, Tri-City Mall Associates, Koll Center Newport Number 1, Koll Center Newport Number 2, Koll Center Newport Number 4, Koll Center Newport Number 7, Koll Center Newport Number 8, Koll Center Newport Number 9, Koll Center Newport Number 10, Koll Center Newport Number 11, Koll Center Newport Number 14, Koll Center Newport Number 15, Aetna Hamilton Partnership, Southwest Financial Center Associates, Ensenada de Las Colinas I Associates, B & H Ventures IV Limited Partnership, KBC-Red Hill Limited Partnership, Gables at Farmington Associates, Country Club at Woburn Heights Associates, Oaks at Valley Ranch II, American Health Capital Insurance Company, Ltd., Epic Center Joint Venture, Paces Common Limited Partnership, Marriott Inner Harbor Hotel, KBC-Eastside Limited Partnership, Biltmore Fashion Park Associates, Chris-Town Village Associates, 1800 West Loop Tower Associates, Tysons I Limited Partnership, Lincoln Forest Village Associates, LPFVA Two, Raintree-Carlton Court Associates, Hayward Industrial Park Associates, Colonnade II, Dayton Arcade Partnership, Lincoln Benicia IV & V, KBC-Paradise Valley Limited, LPFVA Three, 455 Market Street, Koll Prospect Partnership, Tysons II Associates Limited Partnership, Lincoln Rancho Cucamonga Associates, 1670 Broadway Joint Venture, Parkway Central Plaza, Birtcher Aetna-Laguna Hills, Harbor Business Park, West Windsor Limited Partnership, Fairway Partners, Katahdin Partners, Aetna Institutional Investors I Limited Partnership,

Human Affairs of Alaska, Dexter Park Limited Partnership, Deerfield Road II Ltd. Partnership, Gables at Brighton Associates, 1501 Fourth Ave. Limited Partnership, Wayne Towne Associates, The Meadows at Centennial Downs, Eastmeadow Distribution Center Limited Partnership, Lincoln Terrace Limited Partnership, Lincoln Club Associates Limited Partnership, Forge Park Associates, ADB I, Woodside Terrace Partners, Koll Business Center-Alton, TCR-Ventanja Limited Partnership, Centrum Associates, ARB-DTC Ltd. Partnership, Centrum II Associates, Golf Course View Partnership, Spectrum Fashion Center, Oaks at Valley Ranch, Lincoln Oaks Associates Limited, Lincoln Los Padres, Shadow Oaks, Shadow Ridge at Oak Park Condominium Associates, Cambridgeside Galleria, Village Green of Madison Heights, Partners National Health Plans, Partners Joint Acquisition Company, Inc., Med Southwest, Inc., Lincoln Rittenhouse Associates, Ensenada de la Colinas II Associates, Ltd., F-L Properties, Healthmaster, Inc., Independence HMO, Inc., Virginia Mason Health Plan, Inc., Partners Health Plan of Northern Ohio, Inc., Partners Health Plan of Colorado, Inc., Partners Health Plan of Florida, Inc., Indiana Medcenters, Inc., Network Health Plan of Wisconsin, Inc., Healthways, Inc., Partners Health Plan of Pennsylvania, Inc., Community Health Services, Inc.

Respondent has no other parent company, subsidiary, or affiliate within the meaning of Rule 29.1 of the Rules of this Court.